REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Home Manager, Appleton Lodge Care Home.**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 6th October 2014 I commenced an investigation into the death of **Maria Silkin** dob 9th February 1927. The investigation concluded on the 6th February 2015 and the conclusion was one of **Accidental Death**. The medical cause of death was 1a Left lower lobe pneumonia and surgical wound infection 1b Fractured right neck of femur (operated on 11.9.14) and 11. Ischaemic heart disease and aortic valve stenosis.
4	**CIRCUMSTANCES OF THE DEATH** **On or about the 2nd September 2014 she fell at the Care Home and broke her hip. It was then a week before she was taken to hospital. She was operated on and then developed pneumonia.**
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. During the course of the evidence the Care Home produced a document entitled "Falls Risk Assessment". In part of that document it was indicated that the "falls history " showed there had been no previous falls whereas I had already heard evidence which was not challenged, to the effect that she had previously fallen numerous times. 2. Because of the above, the action to take her to hospital was, in my opinion, delayed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **16th April 2015**. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely [redacted] **(nominated next of kin).** I have also sent it to the **Care Quality Commission** who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**19.2.15** [redacted] **John Pollard, HM Senior Coroner**